U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 24Aug2001

CASE NO.: 2000-BLA-564

In the Matter of

HARVEY N. OHLER,
Claimant

v.

ISLAND CREEK COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Robert J. Bilonick, Esq.,
For the Claimant

William S. Mattingly, Esq.,
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS[1]

This proceeding arises from a duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed on March 10, 1999. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

[1] Sections 718.2 and 725.2(c) address the applicability of the new regulations to pending claims.

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers pneumoconiosis" "CWP") as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed his first prior claim for benefits on September 10, 1984. (Director's Exhibit ("DX") 38-1). The claim was denied, on February 7, 1985, because the evidence failed to establish Mr. Ohler's CWP was caused at least in part by coal mine work or that he was totally disabled due to pneumoconiosis. (DX 38-14). His second claim, filed on January 1, 1991, was denied on May 31, 1991, because he did not establish any of the elements of entitlement or a material change of condition, under § 725.309(d). (DX 39-19).

The claimant filed his present claim for benefits on March 10, 1999. (Director's Exhibit ("DX") 1). The claim was approved by the district director, on September 3, 1999, because the evidence established the elements of entitlement effective 12/99. (DX 36). On January 11, 2000, the employer requested a hearing before an administrative law judge. (DX 34-35). On March 2, 2000, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs (OWCP) for a formal hearing. (DX). I was assigned the case on June 22, 2000. Interim benefits have been paid by the Trust Fund. (DX 40; TR 55).

On October 18, 2000, I held a hearing in Pittsburgh, Pennsylvania, at which the claimant, and employer were represented by counsel.[2] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-8, Director's exhibits ("DX") 1-41, and Employer's exhibits ("EX") 1- 8 were admitted into the record. CX 12, EX 9 and 10 were admitted post-hearing. CX 9, CX 10, and CX 11, all submitted post-hearing were excluded. The employer's final argument was submitted on January 26, 2001, five days after the effective date of the new Part 718 regulations.

On February 9, 2001, the United States District Court for the District of Columbia, issued a Preliminary Injunction Order, No. 1:00CV03086, *National Mining Associates, et al, v. Chao, et al* (hereinafter "*NMA*"), which generally stays the implementation of many of the new regulatory

[2] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here West Virginia, not the state in which the hearing was held, is determinative of the circuit court's jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust is determinative of the circuit court's jurisdiction. (TR 74).

provisions.[3] In response to my Order, the parties submitted briefs concerning the effects of the new regulations on the outcome of the case. The employer and claimant argued the regulations would affect the outcome and asked the decision be stayed. The solicitor, on behalf of the Director, OWCP, argued the regulations had no effect. The claimant failed to relate the regulations to any specific facts of this case. Without being factually specific, the employer argued the matter could be affected by the change in the definition of pneumoconiosis or the eligibility criteria for disability. Employer's counsel argued a denial of due process by application of the new regulations retroactively. He asked that the case be reopened if the new regulations are followed. I delayed issuing my decision until the NMA case was decided. In August 2001, the District Court upheld the new regulations.

ISSUES[4]

I. Whether the miner has had pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether the miner has at least 36 years of coal mine employment?

VI. Whether there has been a material change in the claimant's condition?

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[3] However, with respect to claims pending before the Office of Administrative Law Judges ("OALJ"), the Court wrote:

> All claims for black lung benefits pending before the Department's Office of Administrative Law Judges at the time of this Order or which become pending within the period set by the Court for briefing, hearing and decision on the merits, shall be stayed for the duration of the briefing, hearing and decision schedule set by the Court, **except** where the adjudicator, after briefing by the parties to the pending claim, determines that the regulations at issue in the instant lawsuit will **not affect the outcome** of the case. (Emphasis Added).

[4] The employer either stipulated to or withdrew its contest of issues 2, 3, 10, 12, and 13 listed on DX 40. (TR 6-8).

FINDINGS OF FACT

I. Background

A. Coal Miner[5]

The parties agreed and I find the claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations,[6] for at least twenty-one years. (Hearing Transcript (TR) 55; DX 1-8; DX 38; DX 39).[7]

B. Date of Filing

The claimant filed his claim for benefits, under the Act, on March 10, 1999. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator

Island Creek Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is not the properly designated responsible coal mine operator in this

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[5] Former subsection 718.301(a) provided that regular coal mine employment may be established on the basis of any evidence presented, including the testimony of a claimant or other witnesses and shall not be contingent upon a finding of a specific number of days of employment within a given period. 20 C.F.R. § 718.301 now provides that it must be computed as provided by § 725.101(a)(32). The claimant bears the burden of establishing the length of coal mine employment. *Shelesky v. Director, OWCP*, 7 B.L.R. 1-34 (1984). Any reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP*, 20 B.L.R. 1-67, 1-72 (1996)(en banc); *Dawson v. Old Ben Coal Co.*, 11 B.L.R. 1-58, 1-60 (1988); *Vickery v. Director, OWCP, 8 B.L.R. 1-430, 1-432 (1986); Niccoli v. Director, OWCP*, 6 B.L.R. 1-910, 1-912 (1984).

[6] § 725.202 Miner defined; condition of entitlement, miner (Applicable to adjudications on or after Jan. 19, 2001).

(a) Miner defined. A "miner" for the purposes of this part is any person who works or has worked in or around a coal mine or coal preparation facility in the extraction, preparation, or transportation of coal, and any person who works or has worked in coal mine construction or maintenance in or around a coal mine or coal preparation facility. There shall be a rebuttable presumption that any person working in or around a coal mine or coal preparation facility is a miner. This presumption may be rebutted by proof that:

(1) The person was not engaged in the extraction, preparation or transportation of coal while working at the mine site, or in maintenance or construction of the mine site; or

(2) The individual was not regularly employed in or around a coal mine or coal preparation facility.

(Emphasis added).

[7] Where there is more than one operator for whom the claimant worked a cumulative total of at least one year, 20 C.F.R. § 725.493(a)(1) imposes liability on the most recent employer. *Snedecker v. Island Creek Coal Co.*, 5 B.L.R. 1-91 (1982)(§ 725.495(a) for claims filed on or after Jan. 19, 2001). One year of coal mine employment may be established by accumulating intermittent periods of coal mine employment. 20 C.F.R. § 725.493(c))(See § 725.101(32) for adjudications on or after Jan. 19, 2001). Under 718.301 (effective Jan. 19, 2001), the length of coal mine employment "must" be computed under 725.101(a)(32) criteria.

case, under Subpart F (Subpart G for claims filed on or after Jan. 19, 2001[8]), Part 725 of the Regulations.

D. Dependents[9]

The claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Mary Lou. (DX 1, 10).

E. Personal, Employment and Smoking History[10]

The claimant was born on July 16, 1927. (DX 1; TR 49). He married Mary Lou, on August 31, 1951. (DX 1). He most recently claimed to have worked in the coal mines for thirty-eight and one-half years, i.e., 7/69-1/10/90 at Island Creek and prior to that or an undetermined time at Bird Coal and Hillman Coal Company. (DX 1, 2; EX 7). He claimed about 25 years in his 1984 claim and 40 years in his 1991 claim. (DX 38-1; DX 39-1). He last worked in the mines, with Island Creek, in January 1990. (DX 1; DX 2). He retired then at age sixty-two. (TR 49). He testified he would have worked until age 65 if he would have had the "air" to do so. (TR 49, 75). He also had noted shortness of breath in 1991. (DX 39-1). He had problems with a productive cough five years before he quit working. (TR 75). The claimant's last position in the coal mines was that of a motor man, a continuos miner operator and timberman. (DX 3; Hearing Transcript (TR) 50).

The claimant, as part of his duties, was required to crawl half mile three hours per day, lift six pounds five hours per day, carry 90 pounds for 100 yards seven to eight times a day, sit and stand for five hours a day. (DX 3; TR 50). As a motorman he engaged in very heavy lifting, loading and hauling. (TR 50). He transferred from continuos miner operator to lower-paying motorman to be in better, less dusty, air. (TR 53). He could no longer perform his last coal mine work because of his shortness of breath. (TR 76).

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[8] § 725.495 Criteria for determining a responsible operator. (**Applicable to claims filed on or after Jan. 19, 2001**).

"(a)(1) The operator responsible for the payment of benefits in a claim adjudicated under this part (the ``responsible operator") shall be the potentially liable operator, as determined in accordance with § 725.494, that most recently employed the miner. . . (b) It shall be presumed, in the absence of evidence to the contrary, that the designated responsible operator is capable of assuming liability for the payment of benefits in accordance with § 725.494(e). . .

(d). . . (when) the operator finally designated as responsible pursuant to § 725.418(d) is not the operator that most recently employed the miner, the record shall contain a statement from the district director explaining the reasons for such designation. If the reasons include the most recent employer's failure to meet the conditions of § 725.494(e), the record shall also contain a statement that the Office has searched the files it maintains pursuant to part 726, and that the Office has no record of insurance coverage for that employer, or of authorization to self-insure, that meets the conditions of § 725.494(e)(1) or (e)(2). Such a statement shall be prima facie evidence that the most recent employer is not financially capable of assuming its liability for a claim. In the absence of such a statement, it shall be presumed that the most recent employer is financially capable of assuming its liability for a claim."

[9] See 20 C.F.R. §§ 725.204-725.211.

[10] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

There is evidence of record that the claimant's respiratory disability may be due, in part, to his history of cigarette smoking. He smoked about a half to a pack per day for a year, no longer, in the service, in 1953, but not since. (TR 62-63).

II. Medical Evidence

A. Chest X-rays[11]

There were thirty-three readings (with three not admitted) of five x-rays, taken between 10/15/84 and 11/04/99. The majority of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102 (b).[12] Fourteen are positive by physicians who, with the exception of Dr. Schaaf, are board-certified in radiology and B-readers.[13] Sixteen readings are negative by physicians who are either B-readers, board-certified in radiology, or both.[14]

Exh. #	**Dates: 1. x-ray 2. read**	**Reading Physician**	**Qualific-ations**	**Film Qual-ity**	**ILO Classif-ication**	**Interpretation or Impression**
DX 38-9	10/15/84 10/15/84	Onderka	BCR		0/1, p/s	Compared tp 1/31/83 no essential change in diffuse findings of CWP.
DX 38-10	10/15/84 12/16/84	Greene	B; BCR[15]	1	1/1, p/q, 6 LZ	
DX 3916	02/06/91 02/06/91	King	B; BCR	1	0/0	Mild diffuse interstitial fibrosis consistent with mild COPD.

[11] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed**.** 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[12] ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of x-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[13] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. §37.51.

[14] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon.* 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's x-ray interpretation "as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on x-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation)."

[15] According to DX 29.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
EX 1	02/06/91 05/01/00	Wiot	B[16]; BCR	2		No evidence of CWP. Ill-defined densities both bases unrelated to coal dust exposure, but etiology unknown
EX 3	02/06/91 06/27/00	Fino	B; BCI(P)	1	0/0	Severe diffuse pulmonary fibrosis middle & lower LZ not representing CWP.
EX 4, EX 9, p. 62-3	02/06/91 07/20/00	W.K.C. Morgan	B	1	1/1, t/s, 4 LZ	No evidence of CWP. No definite emphysema. Fibrosing alveolitis or early interstitial fibrosis inconsistent with dust.
CX 4	02/06/91 08/20/00	Mathur	B; BCR	1	1/1, p/q, 6 LZ	
CX 9 **not** ad-mitted	02/06/91 11/30/00	Brandon	B; BCR	3	2/3, u/u, 6 LZ	ax
DX 16	05/26/99 05/27/99	Mital	B; BCR	1	2/1, t/t, 4 LZ	No active pulmonary disease. Dr. Morgan states t/t opacities are not seen in CWP. (DX 32).
DX 17	05/26/99 08/20/99	P. Barrett	B; BCR	2	2/1, t/s, 6 LZ	Co; em.
DX 26	05/26/99 11/09/99	Fino	B; BCI(P)	1	0/0	Severe pulmonary fibrosis mid & lower LZ not indicative of CWP.
DX 28	05/26/99 12/01/99	Wiot	B; BCR	1		em; IPF; not CWP. Not characteristic of asbestosis. (DX 28).
DX 30	05/26/99 12/08/99	Spitz	B[17]; BCR	1		No evidence of CWP. Compatible with IPF/UIP not from asbestosis. Ih.

[16] The B-reader certificate submitted at DX 28 expired 6/30/99 prior to Dr. Wiot's readings although he indicated on the reading forms that he was a B-reader.

[17] Dr. Spitz's resume shows his B-reader status ended 4/30/97, yet he indicates on each reading his is a B-reader. (DX 30).

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
DX 32	05/26/99 01/26/00	W.K.C. Morgan	B	1	½, 6 LZ	em; hi; recticular nodulation pattern. Consistent with other disease (not dust). Idio PF suggested.
CX 5	05/26/99 08/20/00	Mathur	B; BCR	1	½, p/q, 6 LZ	ax
CX 10 **not** ad-mitted	05/26/99 11/30/00	Brandon	B; BCR	2	3/3, u/u, 6 LZ	ax
DX 31,	05/26/99 12/24/99	Meyer	B; BCR	1		Irregular opacity consistent with UIP/Idiopathic PF not CWP.
DX 13, CX 12, pp. 23, 75	07/01/99 07/01/99	Schaaf	BCI(P)	1	½, , p/s, 6 LZ	Consistent with CWP.
DX 26	07/01/99 11/09/99	Fino	B; BCI(P)	1	0/0	Severe Pulmonary Fibrosis mid & lower LZ not indicative of CWP.
DX 28	07/01/99 12/01/99	Wiot	B; BCR	1		No CWP. Em; IPF. Not characteristic of asbestosis. (DX 28).
DX 30	07/01/99 12/08/99	Spitz	B; BCR	2		No evidence of CWP. Compatible with Interstitial PF not from asbestosis.
DX 31	07/01/99 12/24/99	Meyer	B; BCR	2		No evidence of CWP. Compatible with IPF/UIP. Ho; hi.
DX 32	07/01/99 01/26/00	W.K.C. Morgan	B	3	1/1, t/s, 6 LZ	Em; hi; reticular nodulation pattern. Consistent with other disease (not dust). Idio PF suggested.
CX 1	07/01/99 03/25/00	Mathur	B; BCR	2	2/2, q/r, 6 LZ	

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific-ations	Film Qual-ity	ILO Classif-ication	Interpretation or Impression
CX 6	07/01/99 08/15/00	Brandon	B; BCR	2	3/3, u/r, 6 LZ	ax
DX 26, EX 10, p 45-46	11/04/99 11/09/99	Fino	B	1	0/0	Severe Pulmonary Fibrosis mid & lower LZ not indicative of CWP.
DX 28	11/04/99 12/01/99	Wiot	B; BCR	1		em; IPF; no CWP
DX 30	11/04/99 12/08/99	Spitz	B; BCR	1		No evidence of CWP. Compatible with IPF not from asbestosis. (DX 30).
DX 31	11/04/99 12/24/99	Meyer	B; BCR	2		ca; ho; hi; consistent with IPF/UIP not CWP. Can't exclude malignancy.
DX 32	11/04/99 01/26/99	W.K.C. Morgan	B	2	½, 6 LZ	em; hi; reticular nodulation pattern. Idio PF suggested. Early honeycombing.
CX 2	11/04/99 03/25/99	Mathur	B; BCR	1	2/3, q/r, 6 LZ	
CX 7	11/04/99 08/18/00	Brandon	B; BCR	2	3/3, u/r, 6 LZ	ax
CX 11 post-hearing **not** admit-ted	11/04/99 11/20/00	Schaaf			2/2, q/p	Objected to by employer.

* A- A-reader; B- B-reader; BCR- board-certified radiologist; BCP-board-certified pulmonologist; BCI= board-certified internal medicine; BCI(P)= board-certified internal medicine with pulmonary medicine sub-specialty. Readers who are board-certified radiologists and/ or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 N.16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997))*(en banc)*(*Unpublished*). If no categories are chosen, in box 2B(c) of the x-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[18]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

Physician Date Exh.#	**Age Height**	**FEV_1**	**MVV**	**FVC**	**Tracings**	**Comprehension Cooperation**	**Qualify * Conform****	**Dr.'s Impression**
Bloom 10/15/84 DX 38-6	57 69"	2.69	105.36	3.71		Good Good	No*	Suggests early obstructive pulmonary impairment. Fino finds normal ruling out obstruction, restriction, or ventilatory impairment. (DX 29). Dr. Morgan finds normal. (DX 32; EX 9, p. 75). Dr. Spagnolo suggests mild airflow obstruction, but no restriction. (EX 5).
St. Frances 04/17/90 DX 25, 39	62 68"	2.49	93	3.41	Yes		No*	Dr. Morgan finds test valid. (DX 32). Dr. Spagnolo finds no evidence of chronic fixed obstruction or restriction. (EX 5).

[18] § 718.103 (a)(Effective for tests conducted after Jan. 19, 2001(see 718.101(b))), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function tests are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Com-prehen-sion Cooper-ation**	**Qualify * Conf-orm****	**Dr.'s Impression**
Parcinski 02/06/91 DX 39-11	62 68"	2.42 2.36+	116.36 130.03 +	3.24 3.20+	Yes	Good Good	No* No*	Mild obstructive impairment. Fino finds PFS invalid due to premature termination of exhalation & lack of reproducibility on tracings. Fino finds no ventilatory impairment. (DX 29). Dr. Lantus finds PFS technically acceptable. (DX 39-15). Dr. Spagnolo finds no obstructive impair-ment but can not determine if a restric-tion exists. (EX 5).
St. Frances 03/25/93 DX 25	65 68"	2.26	92	3.25	Yes		No*	Dr. Spagnolo finds no evidence of chronic obstruction or restriction. (EX 5).
Malhotra 04/12/99 DX 11	71 66.5"	2.23	88	3.35	Yes	Good Good	No*	No post-bronchodilator because of dyspnea. Dr. Spagnolo finds no evidence of chronic fixed obstruction or restriction but there may be very mild airflow obstruction. (EX 5). Dr. Morgan finds a gradually wors-ening lung function with a mild restrictive impairment. (EX 9, p. 81).

Physician **Date** **Exh.#**	**Age** **Height**	**FEV_1**	**MVV**	**FVC**	**Tra-cings**	**Com-prehen-sion Cooper-ation**	**Qualify * Conf-orm****	**Dr.'s Impression**
Schaaf 07/01/99 DX 13	72 67"	2.08 2.12+	83 77+	3.32 3.37+	Yes	Good	No* No*	Schaaf finds abnormal with mild obstructive LD. Mild airflow obstruction but normal vital capacity. (DX 13). He finds PFS valid. (CX 12, p. 22). Dr. Morgan agrees there may be mild obstruction. (DX 32; EX 9, p. 82). Dr. Spagnolo finds no evidence of restriction, but there may be very mild airflow obstruction. (EX 5).
Fino 11/04/99 DX 26	72 67"	1.96 1.99+	75 80+	3.14 3.32+		Good	No* No*	Malhotra finds abnormal FEV-1 & FVC. (Dep. 45-6). Dr. Spagnolo finds no evidence of restriction, but there may be very mild airflow obstruction. (EX 5).

* A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

+Post-bronchodilator.

Appendix B (Effective Jan. 19, 2001 for tests on or after that date) states: "(2) The administration of pulmonary function tests shall conform to the following criteria:

(i) Tests shall not be performed during or soon after an acute respiratory illness. . ."

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve this degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

For a miner of the claimant's height of sixty-seven inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.63 for a male 72 years of age.[19] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.12 or an MVV equal to or less than 65; or a ratio equal to or less than 55% when the results of the FEV1 test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Height	age	FEV_1	FVC	MVV
69"	57	2.01		
68"	62	1.87		
68"	65	1.82		
66.5"	71	1.60		
67"	72	1.63	2.12	65

C. Arterial Blood Gas Studies[20]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	**Physician**	**PCO_2**	**PO_2**	**Qualify**	**Physician Impression**
10/15/84 DX 38-8	Bloom	39 41+	62 66+	No No+	Fino finds mild hypoxia. (DX 29; EX 10, p. 75). Dr. Morgan finds mild hypoxia. (DX 32; EX 9, p. 75-6). Schaaf finds significant hypoxemia. (CX 12, p. 35).

[19] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the test are "qualifying." *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 67.5" here, his average reported height.

[20] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. § 718.204(b)(2) permits the use of such studies to establish "total disability." It provides:
In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability: . ..
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part . . .

Date Ex.#	Physician	PCO_2	PO_2	Qualify	Physician Impression
02/06/91 DX 39-14	Parcinski	38 32+	60 64+	Yes Yes+	Dr. Morgan finds suggestion of moderate hypoxia. (DX 32). Morgan says obesity affects test. Dr. Lantos finds test acceptable. (DX 32). Fino agrees it's mild hypoxemia which, at rest, is not debilitating. (EX 10, p. 72).
05/26/99 DX 11, 14	Pickerill BCI(P))	36 39+	66 40+	No Yes+	Dr. Malhotra finds resting hypoxemia on exercise. Mild reduction in PO_2 resting & severe reduction on exercise. Dr. Ranavaya finds test acceptable. (DX 14). Malhotra finds valid. (Dep. 30). Dr. Spagnolo questions validity. (EX 5). Morgan finds exercise response consistent with fibrosing alveolitis. (EX 9, p. 79). Dr. Fino may have found this invalid. (EX 10, p. 69).
11/04/99 DX 26, Ex 10, p. 29	Fino (BCI(P))	39	55	Yes	Abnormal. Moderately severe hypoxia. Malhotra finds significantly bad results. (Dep. 45-6). Dr. Morgan finds worsening progression characteristic of fibrosing alveolitis. (EX 9, p. 83).

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Marvin Bloom, whose credentials are unknown, examined the miner on October 15, 1984. (DX 38-6). He noted a one year pack per day smoking history ending in 1958 and about 38 years of coal mine employment. Based upon history, examination, negative ("0/1") X-ray, non-qualifying PFS, and a non-qualifying AGS, he concluded it was a normal cardio-pulmonary examination.

Dr. Richard Parcinski, whose qualifications are unknown, examined the miner on 02/06/91 and submitted a report. (DX 39-13). Mr. Ohler complained of dyspnea difficulty walking up hills. He noted a non-smoking history and a 20 year coal mine employment history. He observed diffuse bilateral fibrotic crackles on examination. Based on a negative X-ray, non-qualifying PFS showing a mild obstructive defect, qualifying AGS showing mild hypoxemia, examination, normal EKG, and history, Dr. Parcinski idiopathic interstitial pulmonary fibrosis)"IPF") of unknown etiology.[21] He found only a mild impairment from the IPF.

Dr. Vijay K. Malhotra is board-certified in internal medicine. His report, based upon his examination of the claimant, on April 12, 1999, notes at least 31 years of coal mine employment and a non-smoking history. (DX 12). Dr. Malhotra noted the miner's complaint that he could only walk four blocks on level ground, climb thirteen steps or go 200 feet uphill without being impacted by his affliction. He recommended referral for hypoxemia.

Based on examination, history, arterial blood gases, a non-qualifying pulmonary function study showing severe small airway disease, and a positive ("2/1") chest X-ray, Dr. Malhotra diagnosed CWP due to coal dust exposure and found the miner totally disabled from the same. (DX 12).

Dr. Malhotra was deposed on December 9, 1999. (DX 27). He has extensive experience treating coal miners. Dr. Malhotra reiterated the substance of his earlier report. He testified he had reviewed additional reports, i.e., those of Drs. Fino and Schaaf. (Dep. 44). He explained CWP starts as a small airways disease and in most cases progresses on to large airways disease initially causing obstructive impairment then later restrictive impairment. Once the coal dust particle becomes embedded in lung tissue, the process continues despite cessation of exposure. (DX 27 p. 10). It affects blood gas transfer because the scarred lung tissue impairs the transfer of O2 from the alveoli to the blood vessels. CWP is not a "reversible" disease so, in most cases, bronchodilators really do not improve it. (Dep. 20). He explained the various types of emphysema. (Dep. 64).

According to Dr. Malhotra, Mr. Ohler's expiratory rhonchi were consistent with obstructive lung disease and CWP. (Dep. 21). He expressed concern over the shape and size of the opacities shown by X-ray noting CWP normally yields rounded opacities and normally begins in the upper lung zones. Yet, Mr. Ohler had fibrotic lung changes which could not be otherwise explained and one with CWP may have irregular-shaped opacities. (Dep. 25-29, 59). Moreover, subsequent X-rays, read by Drs. Mital and Barrett, showed involvement of additional lung zones. (Dep. 54). He noted Mr. Ohler's lung disease could be asbestosis, silicosis, or anthracosis because of his coal mine exposures, but the only way to diagnose those afflictions is via autopsy. (Dep. 29). It is not likely asbestosis.

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[21] "Hypoxemia" is defined as "deficient oxygenation of the blood; hypoxia." "Hypoxia" is defined as a "reduction of oxygen supply to tissue below physiological levels despite adequate perfusion of the tissue by blood." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28TH ED. (1994) at 812.

(Dep. 60). Mr. Ohler's inhalation of sand, anthracite and silica, on the job, might account for him showing more linear than rounded opacities. (Dep. 61). He discussed Mr. Ohler's PFS. (Dep. 29-37). His MVV shows severe small airways disease and moderate obstructive disease. (Dep. 36). Dr. Malhotra discussed Mr. Ohler's "significantly abnormal" AGS showing moderate hypoxemia. (Dep. 38-43). Mr. Ohler has no cardiac problem. (Dep. 43-44).

Dr. Fino's tests were consistent with pulmonary fibrosis, according to Dr. Malhotra. (Dep. 46). He disagreed with the former's conclusion it was "idiopathic." because it's clear cause was 39 years of coal mine employment dust exposure ruling out other potential causes. (Dep. 46-47). Moreover, he does not believe Mr. Ohler suffers from IPF because it is an insidious disease which begins slowly at a much younger age. (Dep. 49). Mr. Ohler lacks the symptoms of IPF, i.e., cyanosis and huge clubbing. He believes Dr. Fino diagnosed IPF because of his "0/0" reading of an X-ray. (Dep. 59). Dr. Malhotra admitted, on cross-examination, it would be unusual to some degree for one to suffer from this degree of abnormality with a category "2" X-ray. (Dep. 52). His obstructive and restrictive lung disease are consistent with a coal dust disease, i.e., CWP. (Dep. 58).

Dr. W. K. C. Morgan, a member of a number of societies, is a B-reader and very well published in the field of pulmonary diseases, including CWP and other occupational lung diseases.[22] (DX 32). He received his medical education in the United Kingdom in the early 1950's and has worked with those afflicted with occupational lung diseases. He testified his credentials are the equivalent of board-certification. Dr. Morgan has extensive experience dealing with coal miners. His consultation report, dated February 16, 2000, based upon review of enumerated medical information of the claimant, notes 38.5 years of coal mine employment and a five-year pack per day smoking history reported to Dr. Bloom. He observes Mr. Ohler told Drs. Malhotra and Schaaf he had never smoked.

Dr. Morgan disagreed with Dr. Malhotra's statement that CWP starts in the small airways and progresses to the large airway. (DX 32; EX 9, p. 84-5). He says the large airways are involved only by bronchitis. Nor was Dr. Malhotra correct concerning CWP progression- "It certainly does not progress after exposure has ceased with the exception of some subjects who have PMF." Dr. Morgan, unlike Dr. Malhotra believes the miner was overweight. He notes Dr. Malhotra found expiratory rhonchi, which are not explained by CWP and generally are found in asthma and bronchitis. Others found crackles which are virtually always heard on inspiration. He believes Dr. Malhotra was "poorly informed concerning the type of opacities seen in CWP. He wrote idiopathic pulmonary fibrosis is an affliction which is as common in housewives and bank teller as coal miners. There is no causal relationship between coal mine dust inhalation and interstitial pulmonary fibrosis. He suggests Dr. Malhotra did not know the difference between focal and centriacinar emphysema. Dr. Spagnolo agrees with Dr. Morgan's assessment of Dr. Malhotra's opinion. (EX 5).

Dr. Morgan finds the miner undoubtedly has developed idiopathic pulmonary fibrosis or "fibrosing alveolitis," commonly found in those over 50. Studies suggesting it is more frequent in coal miners are flawed. He opines that Mr. Ohler's condition clearly developed between 1996 to 1997 and is progressing. Since he had no evidence of CWP when he stopped mining, "any deterioration in his

[22] The claimant accepted Dr. Morgan as an expert witness and I find he was so qualified. (TR 36).

lung function cannot have occurred as a result of his exposure to coal dust." The mild obstruction in 1999 could be related to his prior smoking. He has a moderate impairment due to fibrosing alveolitis, a form of pulmonary fibrosis. He is totally impaired partly because of his age, "but mainly because of his interstitial fibrosis unrelated to CWP or his occupation. (DX 32).

Dr. Morgan testified at a deposition, on October 6, 2000 and on November 16, 2000.[23] (EX 8and 9). He reiterated his credentials and the substance of his earlier report. He responded, at length concerning the article he co-authored, "Airway Obstruction, Coal Mining and Disability" and added the paper reflects his current opinions recognizing that some circumstances have changed since 1994. (EX 8, pp. 12-18; EX 9, p. 93-96). He regards simple CWP as "a disease induced by the inhalation of coal dust and the tissue's reaction to its presence." He observed the legal definition includes silicosis which may or may not worsen post-coal mining with further silica exposure and industrial bronchitis which generally improves after exposure ceases. (EX 8, pp. 21, 25). CWP is not a form of interstitial fibrotic disease of the lung, but a nodular fibrosis of the lung. (EX 9, p. 131).

Dr. Morgan believes simple CWP does not progress post-exposure, but a category "2/3", and uncommonly category "1", can become complicated CWP or PMF. (EX 8, p. 22-23, 27-28, 50, 138, 155). Later, he testified CWP is a progressive disease if one's exposure continues, except for those, category "2" or "3", who develop PMF without continued exposure. (EX 9, pp. 86, 138, 155). Dr. Morgan testified that simple medical CWP only progresses radiographically if the miner continues exposure to coal dust. (EX 9, p. 136). He explained simple CWP and simple silicosis differ, in that he has seen miners afflicted with silicosis worsen for three to four years after exposure ceased then stabilize. (EX 9, p. 86, 155).

According to Dr. Morgan, no one knows what causes simple CWP to progress into complicated CWP. (EX 8, p. 25). If complicated CWP, an uncommon disease, appears, it is usually within five years of cessation and usually in younger miners. (EX 8, p. 27). It took over ten pages of deposition testimony for Dr. Morgan to respond to questioning finally expressing his belief that although it is uncommon, one with category "1" X-ray evidence of CWP can, but rarely does, have disabling pulmonary dysfunction. (EX 8, pp. 27-39, 50). X-ray category "2/3" will cause a reduction in PO2 in some persons, but it is exceedingly uncommon in non-smoking radiographic category "1" cases. (EX 8, p. 39-40). In non-smokers, it is exceedingly uncommon for radiographic category "1" CWP for a reduction in PAO2 levels. (EX 8, p. 40). In categories "2/3" there is some mild arteriole hypoxemia. (EX 8, p. 41). He explained how CWP affects gas exchange. (EX 9, pp. 97-98). Aside from category "1" and "2" CWP which show little effect, there is a correlation between the worsening of CWP and falling PO2 levels. (EX 9, pp. 98). Ordinarily, those with category "0" or "1" CWP have normal AGS. (EX 9, p. 99). He is aware of literature showing category "0" or "1" CWPs have uncommonly shown blood gas abnormalities on exercise. (EX 9, p. 100). Dr. Morgan opined obesity is manifested by a restrictive lung impairment. (EX 9, p. 101). The worse the obesity the worse the restriction. (EX 9, p. 102). Dr. Morgan was unaware of literature which suggests CWP can be associated with increased pulmonary hypertension. (EX 9, p. 152). He generally agreed with the standards referenced in exhibit 3 to EX 9, pathology standards. (EX 9, p. 153).

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[23] It would be useful for counsel to advise expert witnesses to refrain from being argumentative with opposing counsel whose duty it is to ascertain their professional knowledge and the bases for their opinions.

Dr. Morgan admitted, on reflection, that his "obesity" explanation for the abnormal 1991 AGS, may not have been entirely accurate since it was in fact the miner's early fibrosing alveolitis which was responsible for the abnormality. (EX 9, p. 126-130, 149). The miner's weight now has negligible impact. (EX 9, p. 150).

Dr. Morgan testified that the changes he observed on the miner's X-rays were consistent with fibrosing alveolitis or idiopathic pulmonary fibrosis, which generally occurs in the elderly and is unrelated to coal mining. (EX 9, p. 66, 73). The disease is characterized by irregular opacities in the lower zones which gradually work upwards and by crackles. (EX 9). He believes there is no question the miner has a totally disabling pulmonary impairment, i.e., fibrosing alveolitis, which nobody knows the cause of. (EX 9, p. 87-89). Although it is difficult to say, the miner's disability probably began around 1991 to 1992. (EX 9, p. 151). He opined it was not caused by his coal dust exposure because it occurs in the general population. (EX 9, p. 89). The miner does not have sarcoidosis. (EX 9, p. 143).

Dr. John T. Schaaf, is board-certified in critical care medicine and internal medicine with a sub-specialty in pulmonary medicine. His report, based upon his examination of the claimant, on July 1, 1999, notes 38.5 years of underground coal mine employment and a non-smoking history. (DX 13). Dr. Schaaf related the miner's complaint that he could not walk uphill or up eight steps without stopping, although he was okay on the level. The miner reported breathing problems when he was still mining. (DX 13).

Based on examination , history, a nonqualifying pulmonary function study showing mild airflow obstruction but normal vital capacity and a ("½") positive chest X-ray, Dr. Schaaf diagnosed CWP and found his disabling dyspnea due to CWP. (DX 13). He added, "In addition, there is no alternative explanation for his breathlessness save to evoke the obvious lung disease that he already has, i.e., coal workers pneumoconiosis." (DX 13).

Dr. Schaaf testified at a deposition on November 20, 2000, which was admitted post-hearing. (CX 12). He reiterated his credentials and the substance of his earlier report. He testified he actively treats patients with various pulmonary afflictions. Since his report he reviewed additional enumerated materials including portions of Dr. Morgan's deposition. He observed Mr. Ohler had been exposed to both rock dust and coal dust in his mining career. (CX 12, p. 17). He did not find him obese or overweight, but did not ascertain his ideal weight. (CX 12, pp. 17, 69). In fact, he disagreed with Dr. Morgan's assessment that the miner's weight played any role in his impairment. (CX 12, p. 42-50, 68). He testified concerning the crackles, sounds associated with interstitial lung disease, such as IPF, he observed on examination of the miner. (CX 12, pp. 19-21, 73). He believes CWP can show both rounded and irregular opacities on X-ray and medical literature reflects the same. (CX 12, p. 25-28, 76-79, 98). He was not aware of any etiology for the miner's interstitial fibrosis other than coal mine dust exposure. (CX 12, p. 29). If Mr. Ohler had a five pack-year smoking history it would have little significance. 9CX 12, p. 31-32). He added that the miner's 1999 AGS results are consistent with simple CWP. (CX 12, p. 33). His 1984 and 1991 AGS showed borderline impairments. (CX 12, p. 34).

Dr. Schaaf defined IPF and ruled it out here. (CX 12, pp. 36, 86-89). He could not imagine the miner had IPF in 1984 and still be living; rather it must have been CWP. (CX 12, p. 39-40, 81). He observed there is no requirement that CWP first appear on X-ray in the upper lung zones, but the traditional description is that it tends to be there. (CX 12, pp. 51-52). Simple CWP can progress post-coal dust exposure and cause worsening pulmonary function. (CX 12, pp. 51-53, 66). One cannot differentiate opacities caused by coal dust versus silicates by X-ray. (CX 12, pp. 54-55). Dr. Schaaf believes the miner's condition has been worsening. (CX 12, pp. 56). It is medically sound for the miner to be utilizing supplemental oxygen and bronchodilators. (CX 12, pp. 57-58). Mr. Ohler has no sarcoidosis. (CX 12, pp. 58-59). Although Mr. Ohler did not retire until 1990, his AGS results (PO2 of 60) showed a severe impairment of lung function. (CX 12, p. 62). While he may, in the strictest definitional sense, have chronic bronchitis, DR. Schaaf did not believe it was his disease process. (CX 12, p. 75).

Dr. Schaaf disagreed with the ATS position that FEV-1 to FVC, which he used to assess the mild obstructive impairment, ratio is not useful in assessing the severity of lung disease, based upon his own clinical experience treating patients. (CX 12, p. 71). He has also found the "percentage of predicted value of the FEV-1" test is not helpful as the sole test of lung function. (CX 12, pp. 71-73).

Dr. Gregory Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, reviewed the claimant's medical records on behalf of the employer, examined him and submitted his opinions in a report, dated November 9, 1999. (DX 26). His report notes thirty-nine years of underground coal mine employment and an "insignificant", pack per day one-year smoking history between 1945 and 1946, which plays no role in his disability. (DX 26; EX 10, p. 40). Dr. Fino reported the X-rays showed severe diffuse pulmonary fibrosis in the middle and lower lung zones ("LZ") not indicative of CWP. He wrote the miner denied shortness of breath while mining. (DX 26). However, later at his deposition, he acknowledged the medical reports show it began in the 1980's. (EX 10, p. 39). Based on examination, history, a normal EKG, a negative X-ray, a nonqualifying PFS showing combined obstructive and restrictive disease, an AGS showing moderately severe hypoxia, Dr. Fino concluded that the claimant did not have pneumoconiosis and diagnosed idiopathic diffuse interstitial pulmonary fibrosis. (DX 26). He opined Mr. Ohler did not suffer from an occupationally-acquired pulmonary condition. Dr. Fino found the miner totally disabled due to his diffuse interstitial pulmonary fibrosis. However, he reported, "[T]here is no causal association between coal mine dust inhalation and the development of diffuse idiopathic pulmonary fibrosis."

Dr. Fino submitted a supplemental report, dated December 10, 1999. (DX 29). He had reviewed additional, enumerated medical information. Looking at a 1984 DOL examination report, he reported Mr. Ohler had smoked a pack a day for five years. A 2/6/1991 DOL examination reported a non-smoking history. He concluded the additional information did not change his opinion that Mr. Ohler has diffuse interstitial pulmonary fibrosis not due to coal mine dust inhalation. (DX 29).

Dr. Fino testified at a deposition, on November 29, 2000. (EX 10). He reiterated his credentials and the substance of his earlier reports. He had had the opportunity to review additional medical information since that time. (EX 10, p. 5). Mr. Ohler does not have sarcoidosis. (EX 10, p. 68). Dr. Fino testified that simple CWP can progress and worsen post coal dust exposure, but it unusual for it to do so. (EX 10, p. 82-83). He testified the X-rays he reviewed, 1991-1999, were

very abnormal with diffuse irregular fibrosis representing a diffuse interstitial pulmonary fibrosis. (EX 10, p. 6). Although he appreciated opacities in the upper lung zones, he did not classify it in accordance with the ILO system because he did not feel it was consistent with a pneumoconiosis Mr. Ohler would be at risk of contracting. (EX 10, pp. 6, 45-47). He agreed the miner was totally disabled, but that it was not due to his coal mine dust exposure. (EX 10, pp. 7-8, 37). The miner has no coal mine dust related pulmonary condition, including "legal" CWP, but diffuse interstitial pulmonary fibrosis. (EX 10, p. 8-9). He primarily has a restrictive defect and some obstruction. The literature, i.e., Alfred Fishman's text, supports the proposition that those with Mr. Ohler's type of pulmonary fibrosis may survive up to twenty years, but the mean survival rate is six to eight years. (EX 10, pp. 16, 80, 84).

Dr. Fino testified the typical CWP opacity is rounded, but one may see "secondary" irregular ones. (EX 10, pp.18-20). He admitted one can see irregular opacities in CWP along with rounded ones. (EX 10, p. 48, 51). However, the mere fact a miner has irregular opacities is not "synonymous" with coal dust inhalation as the cause. (EX 10, p. 19). The Amandus article, referenced in Green's text, concluded the coal miner's studied irregular opacities had been caused by smoking. (EX 10, p. 20). The "Irregular Opacities" article referenced by Dr. Schaaf, did not conclude that the irregular opacities in the 46 men they studied were caused by coal dust exposure, but rather could not say. (EX 10, pp. 21-22, 89). The older one is the more likely to have irregular shaped opacities. (EX 10, p. 89). CWP usually first presents in the upper lung zones. (EX 10, p. 56). Dr. Fino discussed how he classifies X-rays, under the ILO system. (EX 10, pp. 43-45).

According to Dr. Fino, while coal dust may cause diffuse pulmonary fibrosis, studies have not established that. (EX 10, p.22). Dr. Fino testified the Honma article concerning diffuse interstitial fibrosis is of no use in determining whether coal mine dust causes diffuse interstitial fibrosis. (EX 10, pp. 25-16, 65). Dr. Fino does not believe the evidence is sufficient to establish a causal relationship between coal mining and diffuse interstitial fibrosis. (EX 10, p. 62).

Dr. Fino's experience is in line with Green's text statement that the overall prevalence of CWP in coal miners between 1978 and 1980 was slightly less than 5%. (EX 10, p. 26). He agrees with Dr. Green's position that simple CWP does not usually progress post-exposure, however a minority progress to complicated CWP. (EX 10, p. 27-28). Here, Mr. Ohler's pulmonary condition continued to deteriorate from non-disabled in 1991 to disabled in 1999. (EX 10, p. 27). The FEF 25/75 is not useful to rate pulmonary impairment. (EX 10, p. 28). The FEV-1/FVC ratio measures the presence or absence of obstruction, but the degree of obstruction is measured by the absolute FEV-1 value. (EX 10, pp. 28-29). Dr. Schaaf's 1999 PFS was the onset of Mr. Ohler's abnormality. (EX 10, p. 86).

Dr. Fino testified that as individuals age their normal blood oxygen level decreases. (EX 10, pp. 30-34). However, Mr. Ohler's PO2 is below normal. Dr. Fino found the miner overweight, but without effecting his shortness of breath. (EX 10, pp. 34, 41).

Dr. Samuel V. Spagnolo is board-certified in internal medicine with a sub-specialty in pulmonary medicine and is extremely well-published. (EX 6). He reviewed enumerated records relating to the claimant and submitted a consultation report dated August 19, 2000. (EX 5). Dr. Spagnolo noted 38.5 years of coal mine employment and a zero to five year pack per day smoking

history. Based on his review, he found Mr. Ohler does not have any chronic restrictive or obstructive disease arising out of coal mine employment. He observed:

> none of the laboratory reports demonstrates evidence of a significant loss of lung function to account for Mr. Ohler's complaints. Minimal airflow obstruction may be seen when there is extensive lung fibrosis sufficient to result in category 2 or 3 chest radiographic changes. In this situation, total lung capacity is markedly reduced. None of these findings is present in Mr. Ohler. Only one highly questionable blood gas value (Dr. Pickerill in May 1999) over a 16 year period raises the possibility of a clinically significant lung abnormality. . .easily explained by Mr. Ohler's excessive weight. . . the described changes on multiple chest radiographs are not representative of pneumoconiosis of any type. The changes suggest early interstitial lung disease but by no means does this indicate these changes are fibrotic in nature.

(EX 5, page 4). Dr. Spagnolo concluded Mr. Ohler is "not limited" or totally disabled and has "highly questionable evidence of clinically significant lung disease. He has no pulmonary or respiratory impairment attributable to pneumoconiosis or related to his prior coal mine employment. (EX 5). Even if he had CWP, Dr. Spagnolo's opinion regarding impairment would not change.

III. Witness' Testimony

Mr. Ohler testified that he still has breathing problems and is unable to do much about his home. (TR 64). However, he no longer has much of a cough except a productive cough in the mornings. (TR 71). Dr. DeBreeze prescribes his breathing medications. (TR 65). He uses a "puffer" and wheezes in the mornings. (TR 71).

IV. Other

In April 1990, Mr. Ohler was awarded West Virginia State disability benefits for 10 percent disability due to CWP in the amount of approximately $9,000.00. (DX 1, 9; TR 54; 65-66). He was never diagnosed with asthma. (TR 66).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205*; Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). *See Lane v. Union Carbide Corp*., 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP, v.*

Mangifest, 826 F.2d 1318, 1320 (3d Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Since this is the claimant's third claim for benefits, he must initially show that there has been a material change of conditions.[24]

To assess whether a material change in conditions is established, the Administrative Law Judge ("Administrative Law Judge") must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial.[25] *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996) (*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den*. 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995). *See Hobbs v. Clinchfield Coal Co*. 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale*, the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it "differ[s] qualitatively" from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n.11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F. 3d 308 (3rd Cir. 1995).

In *Caudill v. Arch of Kentucky, Inc*., ___ B.R.B. ___, BRB No. 98-1502 (Sept. 29, 2000)*(en banc on recon.*), the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that the miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions. . ."

The claimant's last application for benefits was denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine

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[24] Section 725.309(d) provides, in pertinent part:

> In the case of a claimant who files more than one claim for benefits under this part, . . . [i]f the earlier miner's claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions . . . (Emphasis added).

The new Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067) is not applicable.

[25] *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122, BRB No. 98-0714 BLA (Feb. 19, 1999). Lay testimony, standing alone, regarding the miner's worsened condition, since the denial of his last claim, is insufficient to establish a material change of condition, under 20 C.F.R. § 725.309, absent corroborating medical evidence.

employment; and, (3) the claimant was totally disabled by pneumoconiosis. Under the *Sharondale/Lisa Lee* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits. *Sharondale*.

For the reasons discussed below, I find the miner has established a material change in condition, because he has now proven he suffers from a total disabling respiratory impairment. Moreover, the employer concedes, in his argument, that "[T]he recent medical evidence reveals Mr. Ohler to have a totally disabling pulmonary condition. While the ventilatory studies failed to reveal a significant impairment in the mechanical ventilation of the lungs, diffusion studies and arterial blood gas studies reveal a severe gas transfer impairment associated with a primary lung disease."

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[26] 30 U.S.C. § 902(b) and 20 C.F.R. §718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. §718.201.[27]

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[26] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995) at 314-315. In *Henley v. Cowan and Co.*, 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be "significant and permanent" in order to qualify as CWP, under the Act.

[27] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

(Emphasis added).

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[28] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

" . . . [T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing*, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[29] 20 C.F.R. § 718.202(a)(4).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each

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[28] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases . . . attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See*, e.g., *Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[29] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his or her diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after Jan. 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence.[30] 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP.[31] "[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." *Id.; Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)."(Emphasis added). (Fact one is board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

There were thirty-three readings (three were not admitted) of five x-rays, taken between 10/15/84 and 11/04/99. Fourteen are positive by physicians who, with the exception of Dr. Schaaf, are board-certified in radiology and B-readers. Sixteen readings are negative by physicians who are either B-readers, board-certified in radiology, or both.[32] I find the X-ray evidence in equipoise, neither ruling out nor establishing the existence of clinical CWP. The X-rays do, however, establish the existence of pulmonary fibrosis of one type or another, i.e., diffuse interstitial pulmonary fibrosis, fibrosing alveolitis, idiopathic pulmonary fibrosis, or usual interstitial fibrosis. Several readers, as noted in the table, found emphysema, as well.

"Pulmonary fibrosis" is a peculiar, progressive abnormal thickening of the alveolar walls, of undetermined origin, leading to deficient aeration of the blood with resulting dyspnea and cyanosis and cor pulmonale. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 25th Edition (1974), p. 588. "Diffuse pulmonary fibrosis" is progressive abnormal thickening of the alveolar walls leading to deficient aeration of the blood with resulting dyspnea and death from lack of oxygen or cor pulmonale. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 25th Edition (1974), p. 588. "Pulmonary fibrosis" is referred to as "idiopathic pulmonary fibrosis" which is defined and also referred to as "diffuse pulmonary fibrosis." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, pp. 628-9 (28th Edition,

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[30] "There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. . . *See* N. LeRoy Lapp, '*A Lawyer's Medical Guide to Black Lung Litigation*,' 83 W. VA. LAW REVIEW 721, 729-731 (1981)." Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) at 1359, n. 1.

[31] See Footnote 4.

[32] I note, under the Board's *Cranor* decision, *supra*, I could consider Dr. Morgan's readings as evidence establishing CWP, in spite of his comments.

1994). "Idiopathic pulmonary fibrosis" is defined and also referred to as "diffuse interstitial pulmonary fibrosis." It is a "chronic inflammation and progressive fibrosis of the pulmonary aveolar walls, with steadily progressive dyspnea, resulting finally in death from oxygen lack or right heart failure." The acute, rapidly fatal form is often called *Hamman-Rich Syndrome.* DORLAND'S ILLUSTRATED MEDICAL DICTIONARY,, pp. 628-9 (28th Edition 1994). The term "idiopathic" is used in diagnosing "idiopathic pulmonary fibrosis" when the specific cause is not defined, i.e, in about 50% of cases . THE MERCK MANUAL OF DIAGNOSIS AND THERAPY, Robert Berkow and Andrew J. Fletcher, eds., (16th Ed 1992) page 719. "Fibrosing alveolitis" is idiopathic pulmonary fibrosis. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY,, p. 52 (28th Edition 1994).

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.[33] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and experience, as noted above, I rank Drs. Malhotra, Schaaf, Fino, and Spagnolo more or less equally qualified. I recognize Dr. Malhotra is not Board-certified in the sub-specialty of pulmonary diseases. He makes up for that in experience. Given Dr. Morgan's credentials, I give him slightly less credit than the former physicians. I give lesser credence to the opinions of Drs. Bloom and Parcinski because their qualifications are unknown.

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[33] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp*., 6 B.L.R. 1-1291 (1984). . ."

In *Cornett v. Benham Coal, Inc*., ___ F.3d ___, Case No. 99-3469 (6th Cir. Sept. 7, 2000), the Court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4). (It also rejected Dr. Fino's opinion that the miner's affliction was due solely to smoking and not coal dust exposure because the PFS were not consistent with fibrosis, as would be expected in simple CWP. Fibrosis, while an element of medical CWP, is not a required element of legal CWP).

No treating physician evidence was submitted.[34] In *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *Compare, Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for judge to accord greater weight to treating physician over non-examining doctors). Here, Drs. Morgan, and Spagnolo did not examine the miner, whereas the remaining physicians did.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP,* 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979).[35] This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

The Fourth Circuit "recency" rule is set forth in *Adkins v. Director, OWCP,* 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). It is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the as the earlier. . ." *See also, Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993). Here, both the AGS and physician opinion evidence (except Dr. Spagnolo) show a worsening respiratory impairment. Thus, I give somewhat more weight to the more recent medical evidence.

Both Dr. Malhotra and Dr. Schaaf, on behalf of the claimant, found clinical CWP arising from coal mine employment. Both ruled out IPF. Dr. Malhotra found Dr. Fino's tests consistent with "pulmonary fibrosis" but not "idiopathic pulmonary fibrosis." In the best reasoned and documented evaluation in the record, Dr. Malhotra, who has extensive experience treating miners, explained the miner lacked the symptoms of IPF and his 39 years of coal mine dust exposure essentially ruled out other causes. He opined, in essence, that the lung disease was not "idiopathic" as there was no other reasonable cause than coal dust exposure. He found Mr. Ohler's restrictive and obstructive lung disease consistent with CWP as well as X-rays which showed involvement of additional lung zones, i.e., the upper zones normally associated with CWP. Although concerned with the shape and size of the

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[34] § 718.104(d) Treating physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was, totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the (enumerated) factors in weighing the opinion of the miner's treating physician. The new rule is not applicable to the physician opinions of record, as they were prepared prior to January 19, 2001.

[35] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon.* 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). In a case arising in the Sixth Circuit, the Board held it was proper for the judge to give greater weight to more recent evidence, as the Circuit has found CWP to be a "progressive and degenerative disease." *See Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993) and *Mullins Coal Co. of Virginia v. Director, OWCP*, 483 U.S. 135 (1987).

opacities, he explained, as did Dr. Schaaf, that one with CWP may have irregular-shaped opacities and Mr. Ohler's inhalation of sand, anthracite and silica on the job might account for the more linear than rounded opacities. Although the miner informed both Dr. Schaaf and him he had never smoked, Dr. Malhotra had read Dr. Fino's report which revealed a one-year smoking history. Further, noting Mr. Ohler's hypoxemia, he explained that CWP "affects blood gas transfer because the scarred lung tissue impairs the transfer of O2 from the alveoli to the blood vessels."

Dr. Schaaf found no other alternative explanation for the miner's breathlessness save his CWP. He testified CWP can show both rounded and irregular opacities on X-ray. I observe that Dr. Fino made the same observation. He was unaware of any other etiology for the interstitial fibrosis, which he ruled out here, other than coal mine dust exposure. Had Mr. Ohler suffered from IPF in 1984, he would not likely be living now. Even if he had a five pack year smoking history it would have been of little significance.

Dr. Fino diagnosed diffuse IPF. Dr. Bloom's 1984 opinion that the miner was "normal" is too old to be of much value. Dr. Parcinski's report is also too old to be of much value. Moreover, he was unable to identify the etiology of the "idiopathic" disease. Drs. Morgan, and Fino found some form of pulmonary fibrosis unrelated to occupational exposure. Dr. Spagnolo found early interstitial lung disease unrelated to occupational exposure.

Dr. Morgan noted up to a five year pack per day smoking history. He concluded there is no causal relationship between coal mine dust inhalation and interstitial pulmonary fibrosis or the fibrosing alveolitis, which occur in the general population, particularly the elderly. But, no one knows the cause of fibrosing alveolitis. Unlike Dr. Malhotra, Dr. Morgan believes the miner was over-weight, but that has little impact. He found the condition developed in 1997 and is progressing. According to Dr. Morgan, since Mr. Ohler had no evidence of CWP when he stopped mining, "any deterioration in his lung function cannot have occurred as a result of his exposure to coal dust." The 1999 mild obstruction "could be" related to his smoking. Dr. Morgan concluded Mr. Ohler was impaired by his age and IPF. Dr. Morgan explained, aside from category "0" or "1" CWP which shows little effect, there is a correlation between the worsening of CWP and falling PO2 levels. I observe there were numerous X-ray readings in the higher categories, including a "½" by Dr. Morgan. Relying primarily on negative or lower category X-ray readings, Dr. Morgan did not adequately explain why Mr. Ohler's worsening AGS results were not consistent with the existence of CWP, as his testimony indicates, and as Drs. Malhotra and Schaaf explained.

It appears Dr. Morgan was convinced the miner had IPF from his X-rays because it is characterized by irregular opacities in the lower zones which gradually work upwards and by crackles. However, opacities were found in all lung zones as early as 1984 and thereafter by readers other than Dr. Morgan. Thus, I find this basis for his opinion weak. Further, Dr. Morgan, despite many variations of testimony, essentially believes simple CWP will not progress absent PMF or further exposure to coal mine dust. Although I do not find him hostile to the Act, his view differs from Dr. Schaaf's.

Dr. Fino found no occupationally-acquired lung disease, but rather IPF or diffuse idiopathic pulmonary fibrosis. He admitted the mean survival rate for IPF is six to eight years. He diagnosed primarily a restrictive defect with some obstruction. He admitted although he appreciated upper lung

zone opacities in the miner, he did not classify them in accordance with the ILO system since he did not feel they were consistent with a pneumoconiosis. He did not credit studies linking IPF to coal dust exposure. Although he observed one's blood oxygen level drops as one ages and admitted Mr. Ohler's was below normal, he did not adequately address why Mr. Ohler's worsening AGS results were not consistent with the existence of CWP, as Dr. Morgan's testimony indicated, and as Drs. Malhotra and Schaaf explained nor the etiology of his hypoxemia.

Dr. Spagnolo's review revealed no chronic obstructive or restrictive disease arising out of coal mine employment. He found the X-rays not representative of CWP and, except for one AGS, that Mr. Ohler had no evidence of markedly reduced lung capacity which would be revealed by category "2" or "3" X-ray changes. The changes here suggest early interstitial lung disease, but that does not mean the changes are fibrotic. Even if he had CWP, Dr. Spagnolo's opinion would not change. His opinion is so radically different from the four physicians finding total respiratory disability as to carry little weight. His statement, "[O]nly one highly questionable blood gas value (Dr. Pickerill in May 1999) over a sixteen year period raises the possibility of a clinically significant lung abnormality. . ." is wrong under the Act's scheme. Mr. Ohler had three sets of AGS between 1991 and 1999 which depicted "qualifying" values. Moreover, he was the only one to question the validity of Dr. Pickerill's AGS whereas Drs. Malhotra and Ranavaya found the test valid and Dr. Morgan did not find it invalid. Unlike, Drs. Fino, Malhotra, and Morgan, he found no chronic obstructive or restrictive lung disease, thus, further diminishing the weight I give his opinion. Nor did he adequately address the etiology of the miner's hypoxia.

It appears Dr. Fino, a B-reader, took too myopic a view of the X-rays. Although confirming the 1991-1999 X-rays were very abnormal with diffuse irregular fibrosis representing IPF, he essentially admitted he did not classify the X-ray he read in accordance with the ILO system because he did not feel it was consistent with CWP. This calls into question his reading of all four X-rays as well as his conclusions. Although there was dispute, other readers, who were dually-qualified, did read the X-rays as being consistent with CWP. Because Mr. Ohler's X-rays depicted both irregular shaped and rounded opacities as well as involved all six lung zones over a fifteen year period, I find Dr. Fino's attempts to rule out CWP on the basis of opacity shape and location lacks substantial credibility. Further, while the physicians and medical scholars may argue over the usual initial location and shape of opacities as it applies to clinical CWP, neither the Act or the regulations make a finding of CWP contingent upon those factors. Moreover, although Dr. Fino used the term "legal" pneumoconiosis, his analysis was focused upon factors related to "clinical" CWP. Dr. Fino's belief was that the miner had not experienced shortness of breath until the mid-1990's, but the evidence shows otherwise. Mr. Ohler retired in 1990 at age sixty-two. (TR 49). He testified he would have worked until age 65 if he would have had the "air" to do so. (TR 49, 75). He also had noted shortness of breath in 1991. (DX 39-1). He had problems with a productive cough five years before he quit working. (TR 75).

Basically, we have the opposing physicians seeing the same opacities on X-ray, but reaching differing conclusions. The employer's physicians say the opacities represent IPF of unknown etiology, but unrelated to occupational exposure and found in the general population. The claimant's physicians say the opacities represent CWP and even if it was pulmonary fibrosis the only possible etiology for it is Mr. Ohler's coal dust exposure. Dr. Malhotra found it could be silicosis or anthracosis, but said that could only be verified is by autopsy. He essentially ruled out asbestosis. Cigarette smoking was not determined to be an etiology for the pulmonary fibrosis. The employer's physicians did not discuss

anthracosis or silicosis. Particularly given Dr. Malhotra's explanations, Dr. Fino's apparent non-adherence to the ILO classification scheme, the various physician credentials, and objective results, I find the claimant's physicians' rationales more convincing and more consistent with the evidence. While the 14 positive X-ray readings alone were insufficient to establish CWP, when combined with the medical opinions, I find the evidence establishes the existence of the disease in this light smoker, claimant with decades of coal dust exposure.

There is no legitimate issue of "latency" as Dr. Morgan suggests.[36] There was evidence of CWP as early as 1984, when the claimant was still mining and in February 1991, just a year after Mr. Ohler left the mines. The development of Mr. Ohler's symptoms and the deterioration in his AGS results, starting in 1991, are consistent with the progressive nature of CWP.

A general disability determination by a state or other agency, such as in this case, is not binding on the Department of Labor with regard to a claim filed under Part C, but the determination may be used as some evidence of disability or rejected as irrelevant at the discretion of the fact-finder.[37] S*chegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994); *Miles v. Central Appalachian Coal Co.*, 7 B.L.R. 1-744 (1985); *Stanley v. Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1984) (opinion by the West Virginia Occupational Pneumoconiosis Board of a "15% pulmonary functional impairment" is relevant to disability but not binding). *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Thus, I give the state determination some, but very minor and non-determinative weight as to the existence of pneumoconiosis.[38]

I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d730, 17 B.L.R. 2-64 (3d Cir. 1993).

C. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.[39] 20 C.F.R. § 718.203(b). If a miner who is suffering

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[36] Thus, I find the new regulatory definition of CWP as a "progressive and latent" disease has no affect on the outcome of this claim. Moreover, this Circuit has explicitly recognized CWP as a "progressive" disease, as well as implicitly recognized it as a "latent" disease in its decisions related to the weight to be afforded "recent" evidence.

[37] See § 718.206 "Effect of findings by persons or agencies." (65 Fed. Reg. 80050, Dec. 20, 2000)(Effective Jan. 19, 2001). If properly submitted, such evidence shall be considered and given the weight to which it is entitled as evidence under all the facts before the adjudication officer in the claim.

[38] Counsel points out that West Virginia law provides a presumption of CWP for miners with certain exposures. WV Code § 23-4-8c(b).

[39] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon.* 22 B.L.R. 1-1 (Oct. 29, 1999)(*En banc*). Judge did not err considering a physician's X-ray interpretation "as positive for the existence of

or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).[40]

Since the miner had ten years or more of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Nor does the record contain contrary evidence establishing the claimant's clinical pneumoconiosis arose out of alternative causes. In this claim, as set forth above, the existence of pulmonary fibrosis arising out of his coal mine employment is established. Given the factors discussed in the section above, I do not find the employer has established the miner's pneumoconiosis arose from other than his coal mine employment.

D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[41] Sections 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (iv) reasoned medical opinions concluding the miner's respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[42] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

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pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor's comment." The doctor reported the category I pneumoconiosis found on x-ray was not CWP. The Board finds this comment "merely addresses the source of the diagnosed pneumoconiosis (& must be addressed under 20 C.F.R. § 718.203, causation). Although addressed in the previous section for discussion, I have so considered Dr. Morgan's "positive" X-ray interpretations which he comments are not representative of CWP.

[40] Specifically, the burden of proof is met under § 718.203(c) when "competent evidence establish[es] that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment." *Shoup v. Director, OWCP*, 11 B.L.R. 1-110, 1-112 (1987).

[41] § 718.204 (Effective Jan. 19, 2000). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states:

(a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[42] In a living miner's claim, lay testimony "is not sufficient, in and of itself, to establish disability." *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). See 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miner's claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. Here, none of the PFS have qualifying values and thus do not establish total respiratory disability.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(b)(2)(ii). Four sets of AGS were conducted between 10/15/84 and 11/04/99. With the exception of the pre-exercise test of 5/26/91, all the AGS in the 1990's had "qualifying" results. The 1984 AGS, with non-qualifying" results is too old to be of much use. More weight may be accorded to the results of a recent blood gas study over one which was conducted earlier. *Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993). Thus, I find the AGS establish a total respiratory disability.

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, " . . . all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

I find that the miner's last coal mining positions required heavy manual labor. Because the claimant's symptoms render him unable to perform heavy labor, e.g., crawl, lift and carry, I find he is incapable of performing his prior coal mine employment.

There is no real dispute among the doctors who submitted reports in the 1990's, both examining and consulting, that Mr. Ohler suffers from a total respiratory disability. Drs. Malhotra, Schaaf, Morgan, and Fino agree on that. The evaluations of Drs. Bloom (1984) and Parcinski (1991) are too early to be of great use. Dr. Bloom relied on the early, 1984, non-qualifying AGS. In 2000, Dr. Spagnolo found the miner not disabled by CWP or coal mine dust exposure and that he had "highly questionable evidence of clinically significant lung disease." His opinion is so radically different from the four physicians finding total respiratory disability as to carry little weight. His statement, "[O]nly one highly

questionable blood gas value (Dr. Pickerill in May 1999) over a sixteen year period raises the possibility of a clinically significant lung abnormality. . .” is wrong. Mr. Ohler had three sets of AGS between 1991 and 1999 which depicted “qualifying” values. Moreover, he was the only one to question the validity of Dr. Pickerill’s AGS whereas Drs. Malhotra and Ranavaya found the test valid and Dr. Morgan did not find it invalid.

These physician opinions, combined with the qualifying AGS, establish the miner suffers from a total respiratory disability. The more disputed question is the etiology of this disability.

The Fourth Circuit rule is that “nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis.” *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP,[Hicks]*, 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) *citing Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court wrote it had “rejected the argument that ‘[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments.’” Even if it is determined that claimant suffers from a totally disabling respiratory condition, he “will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems.” *Id*. at 534. The Benefits Review Board has held that nonrespiratory and nonpulmonary impairments are irrelevant to establishing total disability, under 20 C.F.R. § 718.204. *Beatty v. Danri Corp.*, 16 B.L.R. 1-1 (1991).[43] Thus, the miner’s possible obesity, while considered, has no bearing on establishing total disability due to pneumoconiosis.

I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff’g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d730, 17 B.L.R. 2-64 (3d Cir. 1993). I also find the new regulations pertaining to disability have no affect on the outcome of this claim.

E. Cause of total disability[44]

The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words “material” and “materially”, results in “evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner’s total disability is insufficient to establish that

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[43] The Board recently held that its earlier statement, in *Carson*, that “The disabling loss of lung function due to extrinsic factors, e.g., loss of muscle function due to stroke, does not constitute respiratory or pulmonary disability pursuant to 20 C.F.R. § 718.204(c),” was incorrect and struck the language from its opinion. *Carson v. Westmoreland Coal Co.*, 20 B.L.R. 1-64 (1996), *mod’g on recon*., 19 B.L.R. 1-16 (1994).

[44] *Billings v. Harlan #4 Coal Co.*, ___ B.L.R. ___ , BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor’s opinion on causation simply because the doctor did not consider the claimant’s respiratory impairment to be totally disabling.

pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 79946 (Dec. 20, 2000).[45]

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of the claimant's total disability.[46] *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245. The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc), overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff'd* 49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.*.(So, one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability).

Where an Administrative Law Judge determines that a miner suffers from pneumoconiosis, a medical opinion finding the miner does not suffer from the disease "can carry little weight" in assessing the etiology of the miner's total disability. *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 116 (4th Cir. 1995). See *Grigg v. Director, OWCP*, 28 F.3d 416, 419 (4th Cir. 1994) which held if a physician finds no respiratory or pulmonary impairment based on an erroneous diagnosis that the miner does not suffer from pneumoconiosis, her opinion is "not worthy of much, if any, weight." *Citing Tussey v. Island Creek Coal Co.*, 982 F.2d 1036, 1042 (6th Cir. 1993). These Fourth Circuit opinions have been limited by *Dehue Coal Co. v. Ballard*, 65 F.3d 1189 (4th Cir. 1995), where the Court noted *Grigg* involved rebuttal of the interim presumption of total disability found in Part 727.203(a)(1), based

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[45] Effective January 19, 2001, § 718.204(a) states, in pertinent part:
For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

[46] *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (4th Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause.," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or substantial' cause." Id.

on x-ray evidence.[47] In such cases, the doctor's opinion finding no CWP simply contradicts the established presumption without offering rebuttal evidence regarding the cause of the miner's disability. Thus, I do not discredit the employer's physicians on this ground.

There is some evidence of record that claimant's respiratory disability may be due, in part, to his undisputed history of cigarette smoking. However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally, Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990).

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir. 1990).[48]

The debate over the etiology of the miner's total respiratory disease and disability was resolved in my findings concerning the existence of the disease. All those physicians finding total respiratory disability attributed it to either his CWP or pulmonary fibrosis and not smoking or his weight. Since I have determined that, in this case, the miner's pulmonary fibrosis constitutes CWP, as defined in the Act and regulations, i.e., that it arose from his coal mine dust exposure, and that the miner has CWP, it is established those afflictions are the source of his total respiratory disability.

F. Date of entitlement[49]

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis.[50] 20 C.F.R. § 725.503. Dr. Parcinski found only a mild impairment in 1991, in spite of a "qualifying" AGS result. Dr. Morgan opined the claimant's condition clearly developed between 1996 to 1997 and is progressing. The miner's pre-exercise AGS was thereafter "qualifying" in November 1999. It was at that time Dr. Malhotra found his condition significantly bad. However, he

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[47] *See also, Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821 (4th Cir. 1995)(*Hobbs II*). A physician's opinion that a claimant is not impaired by CWP does not necessarily conflict with a judge's legal conclusion that the claimant suffers from CWP and may have probative value. This is so because the legal definition of CWP is much broader than the medical definition.

[48] "By adopting the 'necessary condition' analysis of the Seventh Circuit in *Robinson*, we addressed those claims . . . in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5." *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

[49] 20 C..R. § 725.503(g) provides: "Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant."

[50] The date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-1310 (1984).

could have reached total disability at any time between 1991 and 1999. Thus, I am unable to ascertain an exact onset date. Therefore, the onset date will be the first day of the month in which he filed his claim. Mr. Ohler filed his claim on March 10, 1999. He is therefore entitled to benefits as of March 1, 1999.

ATTORNEY FEES

Thirty days is hereby allowed to the claimant's counsel for the submission of such an application. Counsels' attention is directed to 20 C.F.R. §§ 725.365- 725.366. A service sheet showing that service has been made upon all the partes, including the claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging of a fee in the absence of an approved application.

CONCLUSIONS

In conclusion, the claimant has established that a material change in conditions has taken place since the previous denial, because he is now totally disabled due to pneumoconiosis. The claimant has pneumoconiosis, as defined by the Act and Regulations. The pneumoconiosis did arise out of his coal mine employment. The claimant suffers from a total respiratory disability. His total disability is due to pneumoconiosis. He is therefore entitled to benefits.

ORDER[51]

It is ordered that the claim of HARVEY N. OHLER for benefits under the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the employer, ISLAND CREEK COAL COMPANY, shall pay[52] to the claimant all benefits to which he is entitled under the Act commencing March 1, 1999.

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RICHARD A. MORGAN
Administrative Law Judge

RAM:dmr

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[51] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001).

Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[52] 20 C.F.R. § 725.502 (a)(1)(65 Fed. Reg. 80085, Dec. 20, 2000) provides "Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by a district director, administrative law judge, Benefits Review Board, or court, notwithstanding the pendency of a motion for reconsideration before an administrative law judge or an appeal to the Board or court, except that benefits shall not be considered due where the payment of such benefits has been stayed by the Benefits Review Board or appropriate court. An effective order shall remain in effect unless it is vacated."

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits, and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e, at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**.[53] A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

[53] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001).

(d) Regardless of any defect in service, **actual receipt** of the decision is sufficient to commence the 30-day period for requesting reconsideration or appealing the decision.